PRINTED: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R	R-C
		157641	B. WING			05/	/28/2014
	ROVIDER OR SUPPLIER EALTHCARE SERVICES	INC		10	REET ADDRESS, CITY, STATE, ZIP CODE 50 E 86TH ST ,SUITE 55-B DIANAPOLIS, IN 46240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS	3	{G 0	000}			
	Home Health Compla 02/24/14, 02/25/14, 0 02/28/14 that resulted	sit for an extended Federal aint Survey completed on 02/26/14, 02/27/14, and d in an Immediate Jeopardy at exit. A survey conducted nediate Jeopardy was					
		42 - Substantiated: Federal of the allegation are cited. s are also cited.					
	Survey date: May 27	and 28, 2014					
	Facility: 003413						
	Medicaid Vendor: 20	0434910					
	Current Census: 21						
	Surveyor: Shannon I	Pietraszewski, RN, PHNS					
	to be corrected as a reconditions and 14 sta	nd 39 standards were found result of this survey. Six (6) andard level deficiencies and were recited. There standards cited.					
	providing its own hon competency evaluation two (2) years starting out of compliance wit 42 CFR 484.14 Orga Administration; 484.1 Plan of Care, and Me	rvices, Inc. is precluded from the health aide training and/or on program for a period of 5/28/14 due to being found the Condition of Participation nization, Services, and 8 Acceptance of Patients, edical Supervision; 484.30 4.36 Home Health Aide					
LABORATORY	 DIRECTOR'S OR PROVIDER/:	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING				-C 28/2014
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		ST ,SUITE 55-B	, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B OSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{G 000}	Comprehensive Asse The Administrator / D informed of this preclu conference on 5/28/1	ical Records; and 484.55 ssment of Patients. irector of Nursing was usion prior to the exit 4 at 2:00 PM. e Elder, MSN, BSN, RN	{G 0	00}			
{G 110}	484.10(c)(2)(ii) RIGH PARTICIPATE The HHA complies wi Subpart I of part 489 maintaining written poregarding advance did the HHA must inform information to the patits policies on advance description of applica may furnish advance patient at the time of	T TO BE INFORMED AND th the requirements of of this chapter relating to olicies and procedures	{G 1	10}			
	Based on agency do and interview, the age patients were provide Directive policy in 1 o	d the agency's Advance					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		157641	B. WING		R-C 05/28/2014
	ROVIDER OR SUPPLIER EALTHCARE SERVICES	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	33/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{G 110}	failed to include the a policy in the admission to the patients at the 2. The Administrato the Chief Executive CPM indicated they we provide a copy of the admission packet. 3. The agency documents dated of information regarding patient Advance Directof an individual's right statutory or as recognistate) and how such the organization 484.12(b) DISCLOST MANAGEMENT The HHA also must of information to the State of the HHA's initial reeach survey, and at the ownership or manager (1) The name and additional ownership or control defined in §\$420.201 this chapter. (2) The name and additional an officer, a director,	cket given to the patients agency's Advance Directive on folder that was distributed start of care. If / Director of Nursing and Officer on 05/28/14 at 12:00 are not aware they needed to agency's policy in the ment titled "Admission 8/22/11 states. "Pertinent at the organization's policy on ctives including a description at under state law (whether nized by the courts of a rights are implemented by JRE OF OWNERSHIP & disclose the following at survey agency at the time quest for certification, for the time of any change in the ement: dress of all persons with an interest in the HHA as 1,420.202, and 420.206 of a dress of each person who is an agent or a managing as defined in §§420.201,	{G 110		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				···		R-C	
		157641	B. WING			05/28/2014	
	ROVIDER OR SUPPLIER EALTHCARE SERVICES	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICE DEFICIENCY)		ON SHOULD BE HE APPROPRIA		
G 120	(3) The name and address of the chairman of the board corporation, associati	dress of the corporation, company that is responsible of the HHA, and the name nief executive officer and the d of directors of that	G	120			
	Based on agency do interview, the agency documentation regard administration were p State Department of I	failed to ensure					
	at 3:00 PM evidenced	anizational chart on 05/27/14 I employee QQ, a as the Assistant Director of					
{G 122}	D, bookkeeper / Hum supposed to have ser after the Professional 05/19/14.	at 12:00 PM that employee an Resources, was at the paperwork to ISDH Advisory Group meeting on	{G 1	22}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						R	-C
		157641	B. WING			05/:	28/2014
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		1050 E 86TH ST ,SUITE 55-B		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{G 122}		not met as evidenced by:	(G 1	122]	}		
	Based on observation and interview, the Adriknowledgeable in ordinagency's everyday furthe potential to affect current patients (See ensure a qualified per the absence of the acceptance of the	n, record and policy review, ministrator failed to be er to organize and direct the nctions and the staff creating all of the agency's 21 G 133); the agency failed to reson was available to act in Iministrator creating the of the agency failed to ensure redinated effectively with the nishing services for 2 of 2 reatients receiving dialysis reprovider creating the of the agency's patients that e service (See G 143); failed were coordinated and					
{G 133}	records reviewed crea all 21 patient's receivi (See G 145). The cumulative effect resulted in the agency	Condition of Participation 42 ation, Services, and	{G 1	133]	}		

PRINTED: 06/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING				-C 28/2014	
	ROVIDER OR SUPPLIER	INC		10	TREET ADDRESS, CITY, STATE, ZIP CODE 050 E 86TH ST ,SUITE 55-B NDIANAPOLIS, IN 46240		-0.2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
{G 133}	under paragraph (d) of directs the agency's of ongoing liaison amon		{G 1	33}				
	Based on observatio and interview, the Adi knowledgeable in ord	not met as evidenced by: n, record and policy review, ministrator failed to be er to organize and direct the nctions and the staff creating all of the agency's 21						
	Findings include:							
	of Nursing, failed to e provided the agency's 2. The Administrator person was available the absence of the ac and 5/28/14, the curre	failed to ensure a qualified to act in an emergency in dministrator. On 05/27/14						
	Department of Health 4. The Administrato efforts were coordinated	ding changes in ovided to Indiana State in a timely manner.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		157641	B. WING			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		00/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
{G 133}	health aide visits had ordered by the physic plan of care had been physician notification 6. The Administrator care were revised an medications, fluid resservice, new / old predurable medical equi 7. The Administrator summary included all changes that occurre 8. The Administrator with the physician in pressures. 9. The Administrator prescriptions were vernanner. 10. The Administrator home health aide car of care.	failed to ensure home been provided only as cian and failed to ensure the n followed in relation to . failed to ensure plans of d included all dialysis strictions, outside meal escribed medications, and all pment / supplies. failed to ensure the 60 day of a patient's condition d. failed to notify and follow up relation to elevated blood failed to ensure that new enified and written in a timely or failed to ensure that the eleplan was following the plan ed to ensure the home services as ordered by the	{G 13:				
	registered nurse prop health aide during su	perly evaluated the home					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE:	
		157641	B. WING			R-	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 1050 E 86TH ST ,SUIT INDIANAPOLIS, IN	TE 55-B	<u> U5/2</u>	28/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 133}	referral. 14. The Administrato comprehensive assess accurate, and consist 15. The Administrato medication profile was 484.14(c) ADMINISTI A qualified person is a	r failed to ensure sments were complete, ent with the patients needs. or failed to ensure the securrent and up to date. RATOR	{G 1				
	Based on observation failed to ensure a quato act in the administrator affect all of the age. Findings include: 1. On 05/27/14, the conditional administrator was not a conditional administrator would conditional administrator would conditional administrator and a conditional administrator of D the Alternate Administrator work that needs help	not met as evidenced by: In and interview, the agency lified person was available ator's creating the potential ncy's 21 current patients. urrent / listed Alternate observed in the agency. urrent / listed Alternate observed in the agency.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		LETED
		157641	B. WING _				-C 28/2014
	ROVIDER OR SUPPLIER	INC		1050	ET ADDRESS, CITY, STATE, ZIP CODE E 86TH ST ,SUITE 55-B ANAPOLIS, IN 46240	1 001	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 137}	Continued From page indicated she was not Administrator could le	t sure if the Alternate	{G 1	37}			
{G 143}	was needed. 484.14(g) COORDINA SERVICES		{G 1	43}			
	to ensure that their ef	ng services maintain liaison forts are coordinated rt the objectives outlined in					
	Based on clinical rec interview, the agency were coordinated effe personnel furnishing reviewed of patients r from another provider	not met as evidenced by: ord and policy review and failed to ensure their efforts ectively with the dialysis services for 2 of 2 records eceiving dialysis services recreating the potential to y's patients that receive e . (# 2 and 11)					
	05/05/14, included a pthe physician for certi 07/03/14. The plan owas receiving dialysis clinical record failed to and / or coordination facility in regards to the	nber 2, SOC (start of care) plan of care established by fication period 05/05/14 to f care evidenced the patient at three times a week. The poevidence communication of care with the dialysis ne patient's dialysis I blood pressures, diet, and					
	-	ter was contacted on d the call on 05/29/14. The					

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER VALCO HEALTHCARE SERVICES INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (Gauge of the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. 2. Clinical record number 11, SOC 04/30/14,			157641	B. WING _			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (G 143) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (G 143) (G 143) (G 143) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (G 143) (G 143) (G 143) (G 143) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			I		1050 E 86TH ST ,SUITE 55-B	03/	20/2014
Dietician from the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. 2. Clinical record number 11, SOC 04/30/14,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	(X5) COMPLETION DATE
physician for certification period of 04/30/14 to 06/28/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient dialysis medications. 3. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 indicated she did not know if patient number 2 was on a fluid restriction or a renal diet and was not aware of the need to include dialysis medications on the plan of care and medication profile. At the time of the exit conference, the Administrator / Director of Nursing had not notified the dialysis center of patient number 2's medication. The Administrator / Director of Nursing had not notified the dialysis center of patient number 2's medication. The Administrator / Director of Nursing lace on admission and every 60 days unless there was a need before the 60 days. 4. A policy titled "Coordination of Services With Other Providers" dated 08/22/11 stated, "A Case Manager will be assigned to be responsible for coordinating services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services." {G 144} 484.14(g) COORDINATION OF PATIENT {G 144}		Dietician from the dia 05/29/14 that patient diet and 1500 ml (mill 2. Clinical record nur included a plan of car physician for certifica 06/28/14. The plan o was receiving dialysis clinical record failed thand / or coordination facility in regards to the medications. 3. The Administrator indicated on 05/28/14 not know if patient nur restriction or a renal of the need to include diplan of care and med the exit conference, the Nursing had not notificated in the number 2's medicated in the patient number 2's medicated in the pati	lysis center indicated on number 2 was on a renal liliter) fluid restriction. Imber 11, SOC 04/30/14, re established by the tion period of 04/30/14 to of care evidenced the patient is three times a week. The o evidence communication of care with the dialysis he patient dialysis medications on the dialysis medications on the dialysis medications on the dialysis medications on the dialysis center of he Administrator / Director of died the dialysis center of dialysis center of dialysis center of dialysis center of dialysis of dialysis center of dialysis dialysi				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		157641	B. WING		R-C 05/28/2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	1 00/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
{G 144}	Continued From page 10 The clinical record or minutes of case		{G 144	1}	
		h that effective interchange, nation of patient care does			
	This STANDARD is not met as evidenced by: Based on clinical record and policy review, and Interview, the agency failed to ensure their efforts overe coordinated and documented effectively with the dialysis personnel furnishing services for of 2 records reviewed of patients receiving itervices from another provider creating the cotential to affect all of the agency's patients that eceive more than one service. (2 and 11)				
	05/05/14, included a the physician for cert 07/03/14. The plan of was receiving dialysis clinical record failed and / or coordination facility in regards to the medications, elevated fluid restrictions. The Dialysis cert	d blood pressures, diet, and ter was contacted on			
	Dietician from the dia 05/29/14 that patient diet and 1500 ml (mil	d the call on 05/29/14. The alysis center indicated on number 2 was on a renal liliter) fluid restriction. The alysis center indicated on number 2 was on a renal liliter fluid restriction.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _		R-C 05/28/ 2	2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	1 03/20/	2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	O BE CO	(X5) OMPLETION DATE
{G 144}	physician for certificat 06/28/14. The plan o was receiving dialysis clinical record failed to and / or coordination facility in regards to the medications. 3. The Administrator indicated on 05/28/14 not know if patient nur restriction or a renal of the need to include diplan of care and med the exit conference, the Nursing had not notific patient number 2's medicated on 10 patient number 2's medicated on 10 patient number 2's medicated on 10 patient number 2	ion period of 04/30/14 to f care evidenced the patient three times a week. The o evidence communication of care with the dialysis he patient dialysis / Director of Nursing at 12:00 indicated she did	{G 14	4}		
{G 145}	Other Providers" date Manager will be assig coordinating services the organization, inclu directly and through o will act as liaison with individuals also provid assure effective coord 484.14(g) COORDINA SERVICES A written summary re to the attending physic	ordination of Services With d 08/22/11 stated, "A Case ined to be responsible for provided to the patient by iding services provided ontract. The Case Manager other organizations or ding care to the patient to dination of related services." ATION OF PATIENT port for each patient is sent cian at least every 60 days.	{G 14	.5}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	•	03/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
{G 145}	interview, the agency summary included all changes that occurred creating the potential receiving services from Findings include: 1. Clinical record nureare established by a period 05/20/14 to 07 and home health aid diagnoses included, diabetes mellitus II, hocclusion, and blind a. The OASIS A 03/21/14 stated the proof to upon admission. b. A skilled nures stated the patient had 164/118 to the left ararm, gait disturbance medications prescrib c. A skilled nures stated the patient had 195/118, chest pain, left arm, mobility proof The patient was instremergency room. d. A clinical add 05/02/14 stated the preading of 195/118, chest pain, left arm, mobility proof The patient was instremergency room.	cord and policy review and a failed to ensure the 60 day of a patient's condition of for 1 of 4 records reviewed of to affect all 21 patient's om the agency. (# 12) Imber 12 included a plan of a physican for the certification of the certification of a physican for the certification of a physican for the certification of a physican for the certification of the certifica	{G 1	45}			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		157641	B. WING		R-C 05/28/2014
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	03/28/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{G 145}	weather and had falle the drive way and bro the emergency visit, to e. A skilled nurs stated the patient had 169/133. f. The 60 day su hypertensive episode brace, and fall with in 2. The Director of Nu unable to provide any	nt reported a fall due to bad en down the stairs leading to oken his/her left leg. During the patient's leg was casted. ing visit note dated 05/15/14 d a blood pressure reading of immary failed to evidence the es, new prescriptions, pain,	{G 14	5}	
{G 156}	08/22/11 stated, "Info 60-day summary reprinclude Reason for recertification if applicand treatment / processor for the patient's resposummary of changes recertification for ong 484.18 ACCEPTANO MED SUPER This CONDITION is Based on clinical recreview and interview, home health aide visi	cable A summary of care edure provided A summary	{G 15	6}	

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION N OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X	COMPLETED		
		157641	B. WING _			R-C 05/28/2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	I	03/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{G 156}	physician notification creating the potential 21 current patients (Splans of care were redialysis medications, meal service, new / cand all durable medic of 4 records reviewed dialysis creating the agency's 21 current prom the agency (See follow up with the phrin condition for 2 of 4 to affect all 21 patien the agency (See G 1 that new prescription for 1 of 4 records rev to affect all 21 patien the agency (See G 1 The cumulative effect resulted in the agency compliance with the 484.18: Acceptance and Medical Supervis 484.18 ACCEPTANO MED SUPER Care follows a written	been followed in relation to for 1 of 4 records reviewed to affect all of the agency's Gee G 158); failed to ensure evised and included all fluid restrictions, outside old prescribed medications, cal equipment / supplies for 3 d for patients receiving potential to affect all of the patients receiving services a G 159); failed to notify and evisician in relation to changes a records reviewed creating ts receiving services within 64); and failed to ensure s were clarified and written iewed creating the potential ts receiving services from 66). It of these systemic problems by being found out of Condition of Participation of Patients, Plan of Care, sion. CE OF PATIENTS, POC,	{G 1			
	Based on clinical red	not met as evidenced by: cord and agency policy , the agency failed to ensure				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 5/28/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	•	0/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{G 158}	as ordered by the ph the plan of care had physician notification creating the potentia 21 current patients. The findings include 1. Clinical record nurincluded a plan of cafor certification perioskilled nursing 1 day and home health aid days a week. The p physician was to be less than 90/50 or granger a. A skilled nursevidenced the patien 169/133. The clinicate the physician was not pressure. b. The clinical record nursevidenced the patien 169/133. The clinicate the physician was not pressure. b. The clinical record nursevidenced the patien 169/134. 2. The Administrato indicated on 05/28/1 not aware of the lack 3. A policy titled "Phof Care" dated 08/22 physician will participation of the lack 19 cm o	sits had been provided only hysician and failed to ensure been followed in relation to in for 1 of 4 records reviewed. It to affect all of the agency's (# 12) Imber 12, SOC 04/30/14, are established by a physician of 03/21/14 to 05/19/14 for a week every other week to services 4 hours a day 7 lan of care stated the notified for blood pressures reater than 180/100. Ising visit note dated 05/15/15 at had a blood pressure of all record failed to evidence of the elevated blood record failed to evidence a sit on 03/22/14, 03/23/14, and If / Director of Nursing 4 at 2:00 PM that she was a of physician notification. In provided in the care planning of the care planning of the elevated blood of the care planning of th	{G 1	58}			
	process by initiating, therapeutic and diag provided in compliar	pate in the care planning reviewing and revising nostic orders. The care ill be note with the therapeutic and daccepted standards and					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING					LETED	
		157641	B. WING_				-C 28/2014
	ROVIDER OR SUPPLIER	L		1050	EET ADDRESS, CITY, STATE, ZIP CODE E 86TH ST ,SUITE 55-B IANAPOLIS, IN 46240	<u> </u>	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 158}	Continued From page practice."	e 16	{G 1	58}			
{G 159}	484.18(a) PLAN OF (CARE	{G 1	59}			
	the agency staff cove including mental statu equipment required, f prognosis, rehabilitati limitations, activities prequirements, medica safety measures to prognosis and the status of	on potential, functional permitted, nutritional stions and treatments, any rotect against injury, discharge or referral, and					
	Based on clinical recinterview, the agency care were revised and medications and perm restrictions, outside in prescribed medication equipment / supplies for patients receiving potential to affect all of	na cath maintenance, fluid neal service, new / old ns, and all durable medical for 3 of 4 records reviewed					
	Findings include:						
	05/05/14, included a the physician for certi 07/03/14 for home he						
	assessment and care	ensive non-skilled conference note dated ne patient was receiving					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		157641	B. WING			1	-C 28/2014	
	ROVIDER OR SUPPLIER			1050	EET ADDRESS, CITY, STATE, ZIP CODE E 86TH ST ,SUITE 55-B ANAPOLIS, IN 46240	1 03/	20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{G 159}	outside service for me to evidence dialysis in and outside service for me to evidence dialysis in and outside service for b. The Dialysis of 05/28/14 and returned Dietician from the dialectician from the dialectician also indicate receiving [name of special processing for processing for the building. 2. Clinical record nurincluded a plan of care physician for certificalectical	week and was receiving an eals. The plan of care failed nedications, fluid restrictions, or meals. center was contacted on d the call on 05/29/14. The lysis center indicated on number 2 was on a renal filiter) fluid restriction. The ed the patient was not recific meal program] but east and lunch through a e patient's apartment mber 11, SOC 04/30/14, re established by the tion period of 4/30/14 to ealth aide services. ensive non-skilled a conference note dated the patient was receiving times a week, had a perma vice for meals. The plan of dialysis medications and receiving perma cath outside service for meals. on profile identified the ed 750 mg (milligrams) of the aday and 1000 mg by Vednesday / Friday. The for list failed to include	{G 1	59}				
	included a plan of car							

(G 159) Continued From page 18 physician for certification period of 03/21/14 to 05/19/14 and 05/20/14 to 07/18/14 with orders for skilled nursing services every other week for medication set up and home health aids services 4 hours a day 7 days a week for activities of daily living assistance. a. The plan of care dated 03/21/14 to 05/19/14 stated the patient had gloves and a life alert emergency system in the DME / supply section. The plan of care falted to be revised to include cane, insulin needles, glucometer and finger sticks, and an arm and leg brace. b. A physician order dated 05/13/14 indicated the patient was to start Klor-Con M20 20 meq (milliequivalent) 1 tab by mouth daily with food, Carvidolol 3.125 mg (milligrams) 2 tabs by mouth twice a day, hydrochlorothiazide 25 mg 1 tab by mouth daily, and htroglycein 0.4 mg 1 tab every 5 minutes, maximum 3 tabs as needed for chest pain. These medications were not included on the plan of care. 4. The Director of Nursing was unable to provide any additional documentation and / or information when asked on 05/28/14 at 12:00 PM. 5. A policy titled "Physician Participation in Plan of Care" dated 08/22/11 stated, "Physician orders will be individualized, based on patient's needs, and include B. Treatments and / or procedures needed, including type, frequency, duration, and goals Orders will be reviewed and revised by the patient's physician based on: Changes in diagnosis or treatment, including procedures, medications and equipment "		DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER VALCO HEALTHCARE SERVICES INC INDIANAPOLIS, IN 46240 INDIANAPOLIS, IN 46240 INDIANAPOLIS, IN 46240 INDIANAPOLIS, IN 46240 REGULATORY OR LSC IDENTIFYING INFORMATION) (G 159) Continued From page 18 physician for certification period of 03/21/14 to 05/19/14 and 05/20/14 to 07/18/14 with orders for skilled nursing services every other week for medication set up and home health aide services 4 hours a day 7 days a week for activities of daily living assistance. a. The plan of care dated 03/21/14 to 05/19/14 stated the patient had gloves and a life alert emergency system in the DME / supply section. The plan of care failed to be revised to include cane, insulin needles, glucometer and finger sticks, and an arm and leg brace. b. A physician order dated 05/13/14 indicated the patient was to start Klor-Con M20 20 meq (millequivalent) 1 tab by mouth daily with food, Carvidolol 3.125 mg (milligrams) 2 tabs by mouth twice a day, hydrothorthizaide 25 mg 1 tab by mouth daily, and nitroglycerin 0.4 mg 1 tab every 5 minutes, maximum 3 tabs as needed for chest pain. These medications were not included on the plan of care. 4. The Director of Nursing was unable to provide any additional documentation and / or information when asked on 05/28/14 at 12:00 PM. 5. A policy titled "Physician Participation in Plan of Care" dated 08/22/11 stated, "Physician orders will be individualized, based on patient's needs, and include. B. Treatments and / or procedures medications and equipment"			157641	B. WING _			
Game Game			INC		1050 E 86TH ST ,SUITE 55-B	P CODE	00/20/2014
physician for certification period of 03/21/14 to 05/19/14 and 05/20/14 to 07/18/14 with orders for skilled nursing services every other week for medication set up and home health aide services 4 hours a day 7 days a week for activities of daily living assistance. a. The plan of care dated 03/21/14 to 05/19/14 stated the patient had gloves and a life alert emergency system in the DME's upply section. The plan of care failed to be revised to include cane, insulin needles, glucometer and finger sticks, and an arm and leg brace. b. A physician order dated 05/13/14 indicated the patient was to start Klor-Con M20 20 meq (millequivalent) 1 tab by mouth daily with food, Carvidolol 3.125 mg (milligrams) 2 tabs by mouth twice a day, hydrochlorothiazide 25 mg 1 tab by mouth daily, and nitroglycerin 0.4 mg 1 tab every 5 minutes, maximum 3 tabs as needed for chest pain. These medications were not included on the plan of care. 4. The Director of Nursing was unable to provide any additional documentation and / or information when asked on 05/28/14 at 12:00 PM. 5. A policy titled "Physician Participation in Plan of Care" dated 08/22/11 stated, "Physician orders will be individualized, based on patient's needs, and include B. Treatments and / or procedures needed, including type, frequency, duration, and goals Orders will be reviewed and revised by the patient's physician based on: Changes in diagnosis or treatment, including procedures, medications and equipment "	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BI O THE APPROPRIA	COMPLETION
G 164 484.18(b) PERIODIC REVIEW OF PLAN OF G 164		physician for certificat 05/19/14 and 05/20/1 skilled nursing service medication set up and 4 hours a day 7 days living assistance. a. The plan of ca 05/19/14 stated the p alert emergency syste section. The plan of cinclude cane, insuling finger sticks, and an a b. A physician of the patient was to sta (milliequivalent) 1 tab Carvidolol 3.125 mg (twice a day, hydrochlemouth daily, and nitro 5 minutes, maximum pain. These medication the plan of care. 4. The Director of Nuany additional docum when asked on 05/28 orders will be individual needs, and include procedures needed, in duration, and goals and revised by the pa on: Changes in diagraprocedures, medication.	tion period of 03/21/14 to 4 to 07/18/14 with orders for es every other week for d home health aide services a week for activities of daily are dated 03/21/14 to atient had gloves and a life em in the DME / supply care failed to be revised to needles, glucometer and arm and leg brace. The dated 05/13/14 indicated art Klor-Con M20 20 meq by mouth daily with food, amilligrams) 2 tabs by mouth corothiazide 25 mg 1 tab by reglycerin 0.4 mg 1 tab every 3 tabs as needed for chest ons were not included on arising was unable to provide entation and / or information //14 at 12:00 PM. The sician Participation in Plan 11 stated, "Physician realized, based on patient's B. Treatments and / or including type, frequency, orders will be reviewed then's physician based nosis or treatment, including ons and equipment "				

STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) G 164 G 164
STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240 ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
G 164

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157641	B. WING		R-C 05/28/2014	
	ROVIDER OR SUPPLIER	SINC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B NDIANAPOLIS, IN 46240	03/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION	
G 164	care physician's office pain to the left side of message was left on the control of the nose bleeds as was having, nor did a physician after 05/01 left shoulder and need the patient had a doof uture and was going report her problems. 2. Clinical record nuture and was going report her problems. 2. Clinical record nuture and was going report her problems. 2. Clinical record nuture established by a certification period 0 nursing and home he patient diagnoses into, diabetes mellitus arterial occlusion, and A skilled nursing evidenced the patient 169/133. The clinicate the physician was not pressure. 3. A policy titled "Mo Reporting to Physician "Clinicians will estable."	call was placed to the primary be to follow up on the patient's of the neck and shoulder. A of the voicemail. Q indicated on 05/28/14 at anot notify neither physician and headaches the patient she follow up with the ck. Employee QQ indicated ctor's appointment in the near go to rely on the patient to to the physician at that time. Inher 12 included a plan of a physician for the 3/21/14 to 05/19/14 for skilled eath aide services. The cluded, but were not limited all, hypertension, cerebral and blind hypertensive eye. In visit note dated 05/15/15 at had a blood pressure of all record failed to evidence of the elevated blood conitoring patient Response / an" dated 08/22/11 stated, lish and maintain ongoing	G 164			
	"Clinicians will estab communication with and appropriate care the communication vauthorized licensed iverbal order will be communication."					

AND BLAN OF CORRECTION INDESTRUCTION NUMBERS		IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 05/28/2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	l	00/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 164	Continued From page	e 21	G 1	64		
G 166	according to the revis 484.18(c) CONFORM ORDERS	ed plan of care." IANCE WITH PHYSICIAN	G 1	66		
	dated with the date on nurse or qualified the	in writing and signed and freceipt by the registered rapist (as defined in section responsible for furnishing or ed services.				
	Based on clinical rec agency failed to ensu was clarified and writ reviewed creating the	not met as evidenced by: ord and interview, the re that new prescriptions ten for 2 of 4 records e potential to affect all 21 vices from the agency. (# 2				
	Findings include:					
	05/08/14 that stated t from 5 mg (milligrams order failed to eviden	physician order dated o increase the amlodipine s) to 10 mg. The physician ce route and frequency of rse had called the doctor to				
	nurse visit note dated patient was prescribe (milligrams) 1 tab twid (potassium suppleme ER (extended release hydrochlorothiazide 2	mber 12 included a skilled 1 04/17/14 that stated the d Carvidolol 3.125 mg ce a day, Klor - Con M20 ent) 20 meq (milliequivalent) 2) 1 tab daily with food, and 1.5 mg 1 tab daily. The nce a verbal order for these				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE COMP	
			7. 50.25			R-	-C
		157641	B. WING			05/2	28/2014
	ROVIDER OR SUPPLIER EALTHCARE SERVICES	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
G 166 {G 168}	medications. The phy order 05/13/14. 3. The Director of Nu unable to provide any and/or information wh 12:00 PM. 4. A policy titled "Ver dated 08/22/11 stated will be verified when the discrepancy in the order is communication of the order is communication."	rsing, employee B, was additional documentation en asked on 05/28/14 at ification of Physician Orders" I, "An order or prescription here is a question or der / prescription and when cated by someone other his / her agent. The order erbal order"	G {G 1	68}			
	Based on clinical recinterview, the Register the plan of care in relator 1 of 4 records revi 21 patients receiving (G 170); the Register that the patient was rebeing admitted to hon records reviewed creall 21 patients receiving (G 172); the Register plans of care were redialysis medications a maintenance, fluid reservice, new / old predurable medical equip records reviewed for preduced in the records reviewed for preduced in the reservice of the records reviewed for preduced in the recor						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION NG		(X3) DATE : COMPI	
		157641	B. WING			R-	·C 2 8/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	DE	1 03/2	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
{G 168}	Nurse failed to notify physician in relation to for 2 of 4 records revi coordinate care with a furnishing services to coordinated effectivel of patients receiving sprovider creating the agency's 21 patients services (G 176). The cumulative effect resulted in the agency compliance with the C 484.30: Skilled Nursi 484.30 SKILLED NUFT The HHA furnishes skaccordance with the passed on clinical rec Registered Nurse faile in relation to physicial records reviewed creareceiving services with Findings include: 1. Clinical record nur care established by a certification period 03 nursing and home helplan of care indicated	and follow up with the pelevated blood pressures ewed and failed to a dialysis facility personnel ensure their efforts were by for 2 of 2 records reviewed services from another potential to affect all of the ethat receive one or more of these systemic problems by being found out of condition of Participation of Services. RSING SERVICES stilled nursing services in colan of care. Into the met as evidenced by: for and policy review, the end to follow the plan of care on notification for 1 of 4 ating to affect all 21 patients thin the agency (# 12).	{G 1				
	90/50 and greater tha	n 180/100. A skilled nursing					

PRINTED: 06/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC	•	1050	EET ADDRESS, CITY, STATE, ZIP CODE DE 86TH ST ,SUITE 55-B NANAPOLIS, IN 46240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 170}	had a blood pressure record failed to evider notified of the elevate 2. A policy titled "Mor Reporting to Physicia "Clinicians will establi communication with the and appropriate care the communication will be obtained order	initiates the plan of care and incitates the plan of care and perma cath particular of the plan of care and incitates and perma cath incitates the plan of care and incitates and perma cath incitates the plan of the plan of the agency's incitates and perma cath incitates and perma ca	{G 1				
	Clinical record nur	mber 2, SOC (start of care)					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157641	B. WING		R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	03/20/2014	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION	
{G 173}	the physician for cert 07/03/14 for home had 27/03/14 for home had 3. The comprehassessment and card 05/05/14 evidenced dialysis three times a outside service for more to evidence the regist plan of care to include restrictions, and outsides of the plan of care to include the plan of care the plan of care the plan of care failed to evidence the plan of care failed to evidence the plan of care the plan of care failed to evidence the plan of ca	plan of care established by iffication period of 05/05/14 to ealth aide services. Itensive non-skilled the conference note dated the patient was receiving an eals. The plan of care failed the distered nurse had revised the edialysis medications, fluid ide service for meals. Itensive non-skilled the patient was receiving an eals. The plan of care failed the distered nurse had revised the edialysis medications, fluid ide service for meals. Itensive non-skilled the patient was not at the call on 05/29/14. The ealysis center indicated on number 2 was on a renal lilliliter) fluid restriction. The ed the patient was not be decific meal program] but east and lunch through a lie patient's apartment In SOC 04/30/14, re established by the attion period of 4/30/14 to	{G 173			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		0/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
{G 173}	patient was prescribe Keppra by mouth twi mouth on Monday / V plan of care failed to nurse had revised thinclude Keppra 750 m. 3. Clinical record nuincluded a plan of caphysician for certifica 05/19/14 and 05/20/skilled nursing service medication set up and 4 hours a day 7 days living assistance. a. The plan of complete the palert emergency system section. The plan of registered nurse had include include cane and finger sticks, and b. A physician of the patient was to state (milliequivalent) 1 tal Carvidolol 3.125 mg twice a day, hydroch	on profile identified the ed 750 mg (milligrams) of ce a day and 1000 mg by Wednesday / Friday. The evidence the registered e plan of care to include to mg by mouth twice a day. mber 12, SOC 03/21/14, re established by the ation period of 03/21/14 to 14 to 07/18/14 with orders for the every other week for a week for activities of daily that are dated 03/21/14 to 14 to 15 to 16 to 16 to 17 to 18 to	{G 17	73}			
	5 minutes, maximum pain. These medicathe plan of care. 4. The Director of N	a 3 tabs as needed for chest tions were not included on ursing was unable to provide nentation and / or information					

PRINTED: 06/03/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157641	B. WING				-C 28/2014
	ROVIDER OR SUPPLIER	INC		10	TREET ADDRESS, CITY, STATE, ZIP CODE D50 E 86TH ST ,SUITE 55-B NDIANAPOLIS, IN 46240	<u> </u>	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 173}	Continued From page	÷ 27	{G 1	73}			
{G 176}	of Care" dated 08/22/ orders will be individuded to the individual to the indiv	prepares clinical and linates services, informs the ersonnel of changes in the	{G 1	76}			
	Based on clinical recinterview, the Register and follow up with the elevated blood pressure viewed and failed to dialysis facility personensure their efforts we for 2 of 2 records revidialysis services from the potential to affect patients that receive of 11, and 12) Findings include: Related to notification	one or more services. (# 2,					
	i. Cimical record hur	nber 11 included a plan of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, Z 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	ZIP CODE	00/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
{G 176}	home health aide sediagnoses included, stage renal disease, hypertension, congerarthropathy. a. A Compreher assessment dated opatient was having ecomplaints of a product a pain level of 9.5 on the worst) to the left daily headaches, and dialysis physician recassistance through the summary state the pen notified of the above the left side of the left side of the left side of the nose bleeds are was having, nor did sphysician after 05/01 left shoulder and needs	a physician for the 704/30/14 to 06/28/14 for vices. The patient's but were not limited to, end chronic airway obstruction, stive heart failure, and assive Non-Skilled 4/30/14 at 7:20 AM stated the pisodes of nose bleeds, active cough, chronic pain at a scale of 1 - 10 (10 being shoulder and neck, frequent / d a poor appetite. The quested medication he agency. The clinical rimary care physician had assessment findings. Idendum note dated 05/01/14 call was placed to the primary e to follow up on the patient's f the neck and shoulder. A the voicemail.	{G 1	76}			
	report her problems 2. Clinical record nu care established by a	to rely on the patient to to the physician at that time. The physician at that time aphysician for the 3/21/14 to 05/19/14 for skilled					

NAME OF PROVIDER OR SUPPLIER VALCO HEALTHCARE SERVICES INC 157641 B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240			A. BUILDING	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B			B. WING	157641		
	05/26/2014	E 86TH ST ,SUITE 55-B				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PRÉFIX
(G 176) Continued From page 29 nursing and home health aide services. The patient diagnoses included, but were not limited to, diabetes mellitus II, hypertension, cerebral arterial occlusion, and blind hypertensive eye. A skilled nursing visit note dated 05/15/15 evidenced the patient had a blood pressure of 169/133. The clinical record failed to evidence the physician was notified of the elevated blood pressure. 3. A policy titled "Monitoring patient Response / Reporting to Physician" dated 08/22/11 stated, "Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient Based on the communication with the physician (or other authorized licensed independent practitioner), a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care." Related to coordination of care 1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by the physician for certification period 05/05/14 to 07/03/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient's dialysis medications, elevated blood pressures, diet, and fluid restrictions. The Dialysis center was contacted on 05/28/14 and returned the call on 05/28/14. The			{G 176	alth aide services. The luded, but were not limited II, hypertension, cerebral II blind hypertensive eye. visit note dated 05/15/15 had a blood pressure of record failed to evidence iffied of the elevated blood nitoring patient Response / n" dated 08/22/11 stated, sh and maintain ongoing he physician to ensure safe for the patient Based on ith the physician (or other adependent practitioner), a brained for any change in the municated to all appropriate sure that care is provided ed plan of care." on of care on of care on of care established by fication period 05/05/14 to f care evidenced the patient is three times a week. The providence communication of care with the dialysis he patient's dialysis is blood pressures, diet, and	nursing and home heap patient diagnoses include, diabetes mellitus II arterial occlusion, and A skilled nursing evidenced the patient 169/133. The clinical the physician was not pressure. 3. A policy titled "Mor Reporting to Physician "Clinicians will establis communication with the and appropriate care the communication will be obplan of care and communication will be obplan of care and communication to plan of care and communication to plan of care and communication will be obplan of care and communication will be obplan of care and communication will be obplan of care and communication to plan of care and communication to plan of care and communication to the physician for certiful or coordination of the physician for certiful or coordination of the physician for coordination of the physician regards to the medications, elevated fluid restrictions. The Dialysis cent	{G 176}

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		157641	B. WING		R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		1 03/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
{G 202}	05/29/14 that patient diet and 1500 ml (mi) 2. Clinical record nu included a plan of caphysician for certifica 06/28/14. The plan was receiving dialyst clinical record failed and / or coordination facility in regards to medications. 3. The Administrato indicated on 05/28/1 not know if patient nurestriction or a renal the need to include oplan of care and methe exit conference, Nursing had not notipatient number 2's m / Director of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless there was a real than the exit conference of Nursing would take place on unless the exit conference of Nursing would take place on the exit conference of Nursing would take place on the exit conference of Nursing would take place on the exit conference of Nursing would take place on the exit c	mumber 2 was on a renal lililiter) fluid restriction. mber 11, SOC 04/30/14, are established by the ation period of 04/30/14 to of care evidenced the patient s three times a week. The to evidence communication of care with the dialysis	{G 17			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 05/28/2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	•	00/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{G 202}	Continued From page	e 31	{G 2	02}		
	Based on clinical recinterview, it was deteronsure that the home following the plan of coreviewed of patients is services and failed to fluid restrictions to the plans for 2 of 2 record receiving dialysis and assistance with meals affect all of the agence were receiving home 124); failed to ensure provided services as 1 of 10 records review affect all of the agence receiving home health and failed to ensure the evaluated the home is reviewed of patients whealth aide services of affect all of the agence receiving home health aide services of affect all of the agence receiving home health and receiving home health	h aide services (See G 125); he registered nurse properly nealth aide for 1 of 3 records who were receiving home creating the potential to				
{G 224}	resulted in the agency compliance with the (484.36: Home Health 484.36(c)(1) ASSIGN HOME HEALTH AIDE	y being found out of Condition of Participation n Aide Services. IMENT & DUTIES OF	{G 2	24}		
	health aide must be p nurse or other appropresponsible for the su	nstructions for the home orepared by the registered oriate professional who is upervision of the home ragraph (d) of this section.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		157641	B. WING			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		00/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{G 224}	Continued From pag	e 32	{G 22	4}			
	Based on clinical recinterview, the agency home health aide can of care for 3 of 3 recovereciving home health include specialty diethome health aide can reviewed of patients receiving home health creating the potential current patients who aide services. (# 2, 2) Findings include: 1. Clinical record nur 05/05/14, included a physician 05/05/14 to aide services 2 hours in the evening 7 days aide was to perform a dressing, hair care, so care, check pressure elimination, medicating ambulation / mobility wheelchair, transfers shower / tub, dangle, and set - up, laundry maintain clean and so any noted malfunction equipment as needed.	nber 2, SOC (start of care) plan of care established by a 0 07/03/14 for home health is in the morning and 2 hours is a week. The home health if assist with bathing, hampoo, skin care, foot eareas, oral care, assist with on reminders, assist with related to walker, to chair, bed, commode, assist with light meal prep , light housekeeping, afe environment, and report ns of durable medical					
		wer, hair care / comb hair,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		157641	B. WING _			R-C 05/28/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	ı	03/20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{G 224}	care, assist with tran meal set up every viscare plan failed to ever renal diet and fluid results to be the diet and fluid results to provide hair of skin care, peri care, a medication reminder with transfer, light howevery visit. The home to evidence the patien fluid restriction. 2. Clinical record nuincluded a plan of ca 04/30/14 to 06/28/14 services for 3 hours weeks. The home heassist with bathing, of skin care, foot care, is medication reminders wheelchair, walker, of shower, assist with lilimit fluids to 6 cups a maintain clean and sany noted malfunction equipment. The home health 4/30/14 identified the provide a tub bath, sin medication reminder dangle on side of beded, and light house home health aide was noted to be the diet and the wall the salth aide wall the sal	reminder, incontinence sfer, light housekeeping, and sit. The home health aide idence the patient was on a striction. home health aide care plan ified the home health aide are / comb hair, oral care, assist with dressing, incontinence care, assist usekeeping, and meal set up e health aide care plan failed nt was on a renal diet and mber 11, SOC 04/30/14, re established by a physician for home health aide per day, 3 days a week for 9 ealth aide was to perform / tressing, hair care, shampoo, hail care, oral care, s, mobility assist with ght meal prep and set up, and day, light housekeeping, afe environment, and report ns of durable medical	{G 22	2.4}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 5/28/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		5/26/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{G 224}	assist with transfer, a meal set up as need care plan failed to ever renal diet and fluid results. Clinical record nuincluded a plan of care 3. Clinical record nuincluded a plan of care 3/21/14 to 05/19/14 services 4 hours a dof care stated the hoperform / assist with shampoo, skin care, care, medication remmobility with tub / shemeal prep and light homeal prep and light home health 03/21/14 stated the home hea	are, assist with dressing, assist with ambulation, and ed. The home health aide ridence the patient was on a estriction. Imber 12, SOC 03/21/14, are established by a physician for home health aide ay 7 days a week. The plan me health aide was to bathing, dressing, hair care, check pressure areas, oral hinders, mobility with cane, ower, and assist with light housekeeping. In aide care plan dated home health aide was to h chair, shampoo hair, hair I care, skin care, peri care, dressing, equipment care, ekeeping, and meal set up wide a tub bath, assist with hinge linen as needed. If (Professional Advisory utes dated 05/19/14, the PAG me health aide care plan that	{G 22				
	recommended by the forms. The new forn plans was not impler	the visit records and was e consultant to change to as for home health aide care nented on 05/23/14. The tor of Nursing indicated the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			R-C		
		157641	B. WING			05/	28/2014	
	ROVIDER OR SUPPLIER	INC		1050	EET ADDRESS, CITY, STATE, ZIP CODE DE 86TH ST ,SUITE 55-B IANAPOLIS, IN 46240			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{G 224}	new form in the recor The Chief Executive (would be inserviced a paperwork or to pick (6. A policy titled "Hor dated 08/22/11 stated Manager, upon initialidevelop the home hea consistent with the co and physician (or othe independent practition 484.36(c)(2) ASSIGN HOME HEALTH AIDE The home health aide ordered by the physic	e on how to implement the d and educate the new staff. Office indicated the staff is they come in to turn in up pay checks. The Health Aide Plan of Care In The patient's Case zation of aide services, will alth aide plan of care, imprehensive plan of care er authorized licensed iner) orders In MENT & DUTIES OF	{G 2					
	Based on clinical recinterview, the agency health aide provided a physician in 3 of 3 recreceiving home health potential to affect all opatients receiving hor 11, and 12) Findings include: 1. Clinical record num 05/05/14, included a pagency health and 12 of 10 o	not met as evidenced by: ord and policy review and failed to ensure the home services as ordered by the cords reviewed of patients in aide services creating the of the agency's current ine health aide services. (#2, where 2, SOC (start of care) colon of care established by a 07/03/14 for home health						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		157641	B. WING _		R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	05/28/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
{G 225}	a. The morning dated 05/05/14 identi was to provide a show oral care, skin care, processing, medication care, assist with transmeal set up every viscare plan failed to evirenal diet and fluid re The home healt 05/06/14 to 05/16/14 encouraged fluids, as and "routine maintenated clinical record failed to shampoo, foot care, or incontinence care, medication reminder, with transfer, light how every visit. The home to evidence the patient fluid restriction. The home healt 05/06/14 to 05/16/14 encouraged fluids, as "routine maintenance clinical record failed to show the patient fluid restriction.	in the morning and 2 hours a week. In ome health aide care plan fied the home health aide wer, hair care / comb hair, peri care, assist with reminder, incontinence offer, light housekeeping, and it. The home health aide dence the patient was on a striction. In aide visit record dated stated the home health aide sisted with the wheelchair, ance" with elimination. The coevidence that dressing, checked pressure areas, eal set up, laundry, and light provided for the patient. In ome health aide care plan fied the home health aide are / comb hair, oral care, assist with dressing, incontinence care, assist usekeeping, and meal set up the health aide care plan failed and was on a renal diet and the home health aide sisted with the wheelchair, "with elimination. The coevidence that hair care / skin care, peri care, assist	{G 22	25}	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		157641	B. WING	B. WING		R-C 5/28/2014	
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CC 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{G 225}	housekeeping, and not can od/30/14 to 06/28/14 services for 3 hours provide a tub bath, some dication reminder, dangle on side of bed, and light housel home health aide was to provide sham hair, nail care, oral can assist with transfer, a meal set up as needed a. The home health aide to eviskin care, peri care, in dangle on side of bed, and light housel bed, and light housel b. The home health aide to eviskin care, peri care, in dangle on side of bed, and light housel c. The home health aide to eviskin care, peri care, in dangle on side of bed, and light housel c. The home health aide to eviskin care, peri care, in dangle on side of bed, and light housel c. The home health aide to eviskin care, peri care, in dangle on side of bed, and light housel complete the c	mber 11, SOC 04/30/14, re established by a physician for home health aide per day, 3 days a week for 9 ealth aide care plan dated home health aide was to kin care, peri care, record bowel movement, d, equipment care, make keeping every visit. The sto change linen weekly and poo hair, hair care / combare, assist with dressing, assist with ambulation, and ed. Talth aide visit record dated dence a tub bath, shampoo, record of bowel movement, d, equipment care, make keeping had been provided. Talth aide visit record dated dence a tub bath, shampoo, record of bowel movement, d, equipment care, make keeping had been provided. Talth aide visit record dated dence a tub bath, shampoo, record of bowel movement, d, equipment care, make keeping had been provided.	{G 225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING				R-C /28/2014	
	ROVIDER OR SUPPLIER			1050	EET ADDRESS, CITY, STATE, ZIP CODE DE 86TH ST ,SUITE 55-B IANAPOLIS, IN 46240	1 03/	20/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{G 225}	bed, equipment care housekeeping had be e. An updated hated 05/15/15 state to provide a shower care, skin care, periode medication reminder dangle on side of bed keeping and meal seplan also indicated the provide incontinence assist with transfer, a equipment care, make (as needed). The home head 05/15/14 failed to evimake bed, light hous reminder had been positive as a week every of aide services 4 hours home health aide care videnced the home shower with chair, shower with chair, shomb hair, oral care, care, assist with drest bed, light housekeep visit and to provide a ambulation, and chair	peri care, dangle on side of make bed, and light been provided. It make bed, and light been provided. It make bed, and light been provided. It make bed, light aide was with the shower chair, oral care, assist with dressing, record bowel movements, d, make bed, light house to up every visit. The care he home health aide was to care, turn and position, assist with ambulation, the bed, and change linen provided. If the aide visit record dated dence dangle on side of bed, ekeeping, and medication rovided. In the established by a physician (19/14 for skilled nursing 1 her week and home health as a day 7 days a week. The re plan dated 03/21/14 health aide was to provide a sampoo hair, hair care / skin care, peri care, nail sing, equipment care, make ing, and meal set up every tub bath, assist with nge linen as needed.	{G 2	25}				
	03/21/14 evidence th	alth aide visit record dated e home health aide ovided range of motion						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C)5/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	•	3720/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{G 225}	record failed to evide provided, shampoo horal care, nail care, e housekeeping was provided. The home he 03/24/14, 03/26/14, a home health aide encrange of motion exemphysician's appointm medication reminder. evidence the home hishower, nail care, or a housekeeping. c. The home he 03/25/14 and 03/27/11 health aide encouraged bed bath. The visit recare and light housekeeping with the care and light housekeeping. d. The home he 03/27/14 evidenced the encouraged fluids an reminder. The visit remeal prep, skin care, comb hair, oral care, care, assist with dress light housekeeping with the control of t	cation reminder. The visit noe that a shower was air, hair care / comb hair, equipment care, and light rovided. alth aide visit records dated and 03/28/14 evidenced the couraged fluids, provided cises, assisted with a ent (03/24/14), and The clinical record failed to ealth aide provided a la care, and light alth aide visit records dated 4 evidenced the home led fluids and completed a lecord failed to evidence nail keeping. alth aide visit record dated the home health aide d provided medication ecord failed to evidence shampoo hair, hair care / skin care, peri care, and	{G 2:	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		157641	B. WING_			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP COI 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	DE	00/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{G 225}	Continued From pag	e 40	{G 2	25}			
	03/31/14, 04/02/14, a home health aide end motion exercises, ph (03/31/14), and medi record failed to evide light housekeeping. g. The home he 04/05/14, 04/06/14, 0 evidenced the home fluids and a provided visit record failed to eskin care, shampoor hail care, skin care, odressing, and light house health aide end motion exercises, ph (04/07/14), and medi clinical record failed care, and light house i. The home health aide end care, and light house in the home health aide end care, and light	cation reminders. The visit since nail care, oral care, and salth aide visit records dated 04/08/14, and 04/10/14 health aide encouraged medication reminders. The evidence meal prep, shower, nair, hair care / comb hair, oral care, assistance with busekeeping. The evidence dated and 04/11/14 evidenced the couraged fluids, range of ysician appointment cation reminders. The to evidence nail care, oral eleeping.					
	oral care, assistance housekeeping. j. The home head 04/12/14, 04/15/14, as of the care o	in dressing, and light alth aide visit records dated and 04/17/14 evidenced the					
	home health aide en	couraged fluids and provided s. The clinical record failed					

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157641	B. WING				R-C /28/2014
	ROVIDER OR SUPPLIER	INC		1050	EET ADDRESS, CITY, STATE, ZIP CODE DE 86TH ST ,SUITE 55-B IANAPOLIS, IN 46240	1 03/	20/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{G 225}	hair care / comb hair, assistance in dressin k. The home he 04/14/14, 04/16/14, a home health aide end motion exercises, and The visit record failed hair care / comb hair, assistance in dressin l. The home hea 04/19/14 and 04/24/1 health aide encourag (04/19/14) provided a routine maintenance, The visit record failed (04/19/14), shampoon ail care, oral care, a light housekeeping. m. The home hea 04/19/14, 04/20/14, 04/20/14, 04/20/14, skin care, comb hair, nail care, dressing, and light house head of the home medication reminders to evidence meal pre 04/22/14), skin care, comb hair, nail care, dressing, and light house head of the home head of	p, skin care, shampoo care, nail care, oral care, g, and light housekeeping. alth aide visit records dated and 04/18/14 evidenced the couraged fluids, range of d medication reminders. It to evidence shampoo care, nail care, oral care, g, and light housekeeping. alth aide visit records dated 4 evidenced the home ed fluids, back rub assistance with appliances / and medication reminders. It to evidence skin care care, hair care / comb hair, ssistance in dressing, and alth aide visit records dated 04/22/14, and 04/24/14 health aide provided s. The clinical record failed p (04/19/14, 04/20/14, shampoo care, hair care / oral care, assistance in busekeeping. alth aide visit records dated 4 evidenced the home ed fluids. The visit record n care, shampoo care, hair care, oral care, assistance	{G 2	25}			
	o. The home he	alth aide visit records dated					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING			1	-C 28/2014
	ROVIDER OR SUPPLIER	1 1		1050	ET ADDRESS, CITY, STATE, ZIP CODE E 86TH ST ,SUITE 55-B ANAPOLIS, IN 46240	1 03/	20/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 225}	home health aide end motion exercises, phy (04/21/14), and medic record failed to evide care, hair care / comb and light housekeepin p. The home he 04/27/14 and 04/29/1 prep, shampoo hair, housekeeping. q. The home he 04/28/14 and 04/30/1 health aide encourag exercises, and medic record failed to evide / comb hair, nail care housekeeping. r. The home head 05/01/14 and 05/02/1 health aide encourag reminders. The visit shower, skin care, shousekeeping. s. The home head of 05/03/14 and 06 health aide encourag appliances / routine in reminders. The clinic	and 04/25/14 evidenced the couraged fluids, range of visician appointment cation reminders. The visit nace a shower, shampoo of hair, nail care, oral care, ng. alth aide visit records dated 4 failed to evidence meal nail care, oral care, and light alth aide visit records dated 4 evidenced the home ed fluids, range of motion ation reminders. The visit nace shampoo care, hair care, oral care, and light alth aide visit records dated 4 evidenced the home ed fluids and medication record failed to evidence a ampoo hair, hair care / oral care, and light alth aide visit visit records 5/08/14 evidenced the home ed fluids, assisted with naintenance, and medication rail record failed to evidence shampoo hair, hair care /	{G 2	25}			
	t. The home hea	alth aide visit records dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157641	B. WING		R-C 05/28/2014	
	ROVIDER OR SUPPLIER	S INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	1 03/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	LD BE COMPLETION	
{G 225}	health aide encourar toileting, and provide The visit record faile care, assistance with housekeeping. u. The home he 05/05/14, 05/07/14, home health aide er motion exercises, ph (05/05/14), and med record failed to evide hair, hair care / com housekeeping. 4. The PAG (Profess meeting minutes dat PAG agreed on a net that was to be imple 5. The Administrator indicated on 05/28/1 health aide care plan identifiable duties as recommended by th forms. The new form plans was not imple Administrator / Directoffice staff wasn't su new form in the record The Chief Executive would be inserviced paperwork or to pick 6. A policy titled "Hotel The Chief The C	114 evidenced the home ged fluids, assisted with ed medication reminders. In do evidence meal prep, nail in dressing, and light ealth aide visit records dated and 05/09/14 evidenced the incouraged fluids, range of hysician appointment lication reminders. The visit ence a shower, shampoo is hair, nail care, and light sional Advisory Group) ted 05/19/14 identified the ew home health aide care plan mented by 05/23/14. It / Director of Nursing 4 at 2:00 PM that the home is do not have the same is the visit records and was the consultant to change to ms for home health aide care mented on 05/23/14. The cord of Nursing indicated the ire on how to implement the ord and educate the new staff. The office indicated the staff as they come in to turn in	{G 22!	5}		
	home health aide se					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 501251			R	-C
		157641	B. WING			05/	28/2014
	ROVIDER OR SUPPLIER	INC		10	REET ADDRESS, CITY, STATE, ZIP CODE 150 E 86TH ST ,SUITE 55-B IDIANAPOLIS, IN 46240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 225}	Manager or other app supervise the home h is provided according	zed to direct the care igned aide The Case propriate clinician will nealth aide to ensure care to plan."	{G 2				
G 229	described in paragrap	(or another professional oh (d)(1) of this section) e visit to the patient's home	G:	229			
	Based on clinical rec the agency failed to e properly evaluated the records reviewed of p home health aide sen to affect all of the age	not met as evidenced by: ord review and interview, ensure the registered nurse home health aide for 1 of 3 patients who were receiving vices creating the potential ency's current patients h aide services. (# 12)					
	physician dated 03/2 nursing 1 day a week health aide services 4. The home health aide evidenced the home I shower with chair, shower with chair, oral care, care, assist with dress	plan of care established by a 1/14 to 05/19/14 for skilled every other week and home 4 hours a day 7 days a week. E care plan dated 03/21/14 health aide was to provide a ampoo hair, hair care / skin care, peri care, nail sing, equipment care, make ng, and meal set up every tub bath, assist with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		157641	B. WING_			R-C 05/28/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	E	03/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 229	Continued From pag	e 45	G 2	229			
	03/21/14 evidence the encouraged fluids, preservises, and medic record failed to evide provided, shampoor oral care, nail care, encousekeeping was possible. The home he 03/24/14, 03/26/14, and home health aide encrange of motion exerphysician's appointment medication reminder.	rovided range of motion cation reminder. The visit cance that a shower was mair, hair care / comb hair, equipment care, and light rovided. Calth aide visit records dated and 03/28/14 evidenced the couraged fluids, provided cises, assisted with a ment (03/24/14), and The clinical record failed to mealth aide provided a					
	03/25/14 and 03/27/7 health aide encouraged bed bath. The visit recare and light house d. The home he 03/27/14 evidenced dencouraged fluids and reminder. The visit remeal prep, skin care, comb hair, oral care,	ealth aide visit record dated the home health aide ad provided medication ecord failed to evidence a shampoo hair, hair care / skin care, peri care, nail esing, equipment care, and					
	03/29/14, 03/30/14, 0 evidenced the home	ealth aide visit records dated 04/01/14, and 04/03/14 health aide encouraged ith medication reminders.					

in the second se		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 05/28/2014		
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 229	shower, skin care, sl comb hair, assistand housekeeping. f. The home he 03/31/14, 04/02/14, a home health aide en motion exercises, ph (03/31/14), and med record failed to evide light housekeeping. g. The home he 04/05/14, 04/06/14, 0 evidenced the home fluids and a provided visit record failed to skin care, shampoor nail care, skin care, dressing, and light housekeeping. h. The home he 04/07/14, 04/09/14, a home health aide en motion exercises, ph (04/07/14), and med clinical record failed care, and light house i. The home he 04/13/14 evidenced encouraged fluids, a routine maintenance The visit record faile shampoo care, hair of	d to evidence meal prep, hampoo hair, hair care / e with dressing, and light alth aide visit records dated and 04/04/14 evidenced the couraged fluids, range of ysician appointment ication reminders. The visit ence nail care, oral care, and alth aide visit records dated 04/08/14, and 04/10/14 health aide encouraged medication reminders. The evidence meal prep, shower, hair, hair care / comb hair, oral care, assistance with busekeeping.	G 2	29				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	SINC		STREET ADDRESS, CITY, STATE, ZIP COI 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	DE	00/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 229	04/12/14, 04/15/14, a home health aide en medication reminder to evidence meal pre hair care / comb hair assistance in dressir k. The home he 04/14/14, 04/16/14, a home health aide en motion exercises, an The visit record faile hair care / comb hair assistance in dressir l. The home he 04/19/14 and 04/24/health aide encourag (04/19/14) provided routine maintenance The visit record faile (04/19/14), shampoon nail care, oral care, a light housekeeping. m. The home he 04/19/14, 04/20/14, evidenced the home medication reminder to evidence meal pre 04/22/14), skin care, comb hair, nail care, dressing, and light he 04/20/14 and 04/22/health aide encourage health aide encourage	alth aide visit records dated and 04/17/14 evidenced the couraged fluids and provided s. The clinical record failed ep, skin care, shampoo care, r, nail care, oral care, ng, and light housekeeping. The alth aide visit records dated and 04/18/14 evidenced the couraged fluids, range of ald medication reminders. If to evidence shampoo care, r, nail care, oral care, ng, and light housekeeping. The alth aide visit records dated the visit records dated the evidenced the home ged fluids, back rub assistance with appliances / r, and medication reminders. If to evidence skin care to care, hair care / comb hair, assistance in dressing, and the aide visit records dated 04/22/14, and 04/24/14 health aide provided s. The clinical record failed ep (04/19/14, 04/20/14, shampoo care, hair care / oral care, assistance in	G	229			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
		157641	B. WING _			R-C 05/28/2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP COD 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		30202014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 229	in dressing, and light o. The home he 04/21/14, 04/23/14, a home health aide end motion exercises, phy (04/21/14), and media record failed to evide care, hair care / comb and light housekeepin p. The home he 04/27/14 and 04/29/1 prep, shampoo hair, in housekeeping. q. The home he 04/28/14 and 04/30/1 health aide encourag exercises, and medic record failed to evide / comb hair, nail care housekeeping. r. The home hea 05/01/14 and 05/02/1 health aide encourag reminders. The visit shower, skin care, sh comb hair, nail care, housekeeping. 2. The home health a dated 05/01/14 indica implemented the hom	care, oral care, assistance housekeeping. alth aide visit records dated and 04/25/14 evidenced the couraged fluids, range of visician appointment cation reminders. The visit ance a shower, shampoo on hair, nail care, oral care, ang. alth aide visit records dated 4 failed to evidence meal anail care, oral care, and light alth aide visit records dated 4 evidenced the home ed fluids, range of motion ation reminders. The visit ance shampoo care, hair care, oral care, and light alth aide visit records dated 4 evidenced the home ed fluids and medication record failed to evidence a ampoo hair, hair care /	G 2	29		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	1 ' '	(X3) DATE SURVEY COMPLETED	
		157641	B. WING			R-C /28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG) BE	(X5) COMPLETION DATE	
G 229 {G 235}	unable to provide any	ursing, employee B, was and additional documentation then asked on 05/28/14 at	G :	229			
{G 236}	Based on clinical recinterview, it was dete ensure clinical record complete documents accepted professional records reviewed creall 21 current patients 236). The cumulative effect resulted in the agency compliance with the 0484.48: Clinical Record 484.48 CLINICAL REAL A clinical record contacurrent findings in acceptation of the plan of appropriate identifying physician; drug, dieta orders; signed and danotes; copies of summattending physician; as	al standards for 3 of 4 ating the potential to affect is receiving services (See G at of these systemic problems by being found out of Condition of Participation ords. CORDS aining pertinent past and cordance with accepted ds is maintained for every	{G 2	236}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING			1	-C 28/2014	
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		050 E 86TH ST ,SUITE 55-B	1 0011	20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{G 236}	interview, the agency records contained accords contained accord documents in accords professional standard reviewed creating the current patients received: 1. Clinical record nur 05/05/14, evidenced at that failed to evidence obtained. The Administrator indicated on 05/28/14 was a self referral and have had a signature referral was obtained. 2. Clinical record nur included a Comprehe Assessment dated 4/2 and inaccurate. The indicate the reason for evidenced the patient to evidence how the impacted the patient to evidence how the impacted the patient's pulmonary assessment was receiving oxygen per minute as needed there was humidificated assessment indicated frequent nose bleeds intermittent treatments breathing treatments,	ord and policy review and failed to ensure clinical curate and complete ance with accepted is for 3 of 4 records a potential to affect all 21 wing services. (# 2, 11, and when the referral form a when the referral was ar / Director of Nursing at 12:00 PM that the patient is assessment failed to be an home health services; at had blurred vision but failed in the patient is a safety; and the patient is at 13 liters is but failed to evidence if ion with the oxygen (nose if the patient was having in and failed to include	{G 2	236}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. B		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 05/28/2014		
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		03/20/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
{G 236}	verbalized compliance provided and the plat assessment failed to (renal diet), appetite "fair" but disease ma poor;" neuro / emotio failed to evidence the antidepressant (paxil safety measures had section and failed to precautions as well a section was left bland patient had oxygen but a care, and information. a. A clinical record nu incomplete referral for referral source and in involved in care, and information. a. A clinical add failed to evidence the was notified of the assessment included diagnoses, no indica incomplete Integume cardiopulmonary assenutritional assessment, and appears of the control of the care assessment, and appears of the control of the care assessment, and appears of the control of the care assessment, and appears of the control of the care assessment, and appears of the control of the care assessment, and appears of the control of the care assessment, and appears of the control of the care assessment, and appears of the care assessment, and appears of the care and identification assessment assessment, and appears of the care and identification and iden	e patient had demonstrated / ce with health education of care; nutritional evidence a weight and diet was checked off as being nagement stated, "Appetite anal / behavior assessment e patient was receiving an), the dose and frequency; I a diagonal line through the indicate bleeding and fall as walker / cane; allergies k; and failed to indicate if the eack up. Imber 12 included an orm that failed to evidence information, other services incomplete patient I endum note dated 03/21/14 e date and time the physician	{G 23					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R- 05/2	C 28/2014
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	ZIP CODE	1 00/2	10/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
{G 236}	incomplete Integument cardiopulmonary assessment, fall risk of care provided / and and care summary 4. The Administrator indicated on 05/28/14 aware of the nurses and Administrator / Direct employee H had turned available for an intervassessments and documents. 5. A policy titled "Cord dated 08/22/11 stated contain sufficient information, describe the provided and results in continuity of care amount contract personnel." 484.55 COMPREHENTENTS Each patient must reconstruct the provide, a patient-special assessment that accument health status at that may be used to oprogress toward achie outcomes. The composition of the provide of the progress toward achie outcomes. The composition of the provide of the provide of the progress toward achie outcomes.	assessment contained an intary status assessment, essment, endocrine assessment, amplification alysis of findings, summary, / Director of Nursing at 12:00 PM that she is assessment errors. The or of Nursing indicated ed in her notice and was not riew for clarifications of cumentation. Intents of Clinical Record will remation to identify the patient's problems and curately document care in detail, and facilitate ong organization and NSIVE ASSESSMENT OF Deeive, and an HHA must exific, comprehensive urately reflects the patient's and includes information demonstrate the patient's	{G 2	36}			
	planning needs. For	the patient's medical, , social, and discharge Medicare beneficiaries, the patient's eligibility for the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		157641	B. WING				-C 28/2014
	ROVIDER OR SUPPLIER	INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240		050 E 86TH ST ,SUITE 55-B		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{G 330}	assessment visit and comprehensive assessment must als current version of the Information Set (OAS language and groupir specified by the Secretary This CONDITION is Based on clinical recinterview, it was deternated the initial assessment assessments assessments were consistent with the particular of care creating the potential receiving services with and failed to ensure the current and up to date creating the potential receiving the	th benefit including both at the time of the initial at the time of the sement. The comprehensive o incorporate the use of the Outcome and Assessment IS) items, using the logs of the OASIS items, as etary not met as evidenced by: ord and policy review and rmined the agency failed to essment visit was held within for 1 of 4 patients reviewed for affect all of the agency's ceiving services (See G	{G 3	330}			
G 332	resulted in the agency compliance with the 0 484.55: Comprehens 484.55(a)(1) INITIAL The initial assessmen	Condition of Participation sive Assessment of Patients. ASSESSMENT VISIT at visit must be held either erral, or within 48 hours of	G	332			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		157641	B. WING			R-C 05/28/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	ZIP CODE	03/26/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
G 332	Based on clinical rec interview, the agency assessment visit was referral for 1 of 4 reco	not met as evidenced by: ord and policy review and failed to ensure the initial held within 48 hours of a ords reviewed creating the of the agency's new patients.	G	332			
G 334	that failed to evidence obtained. Therefore, the initial assessmen The Administrate indicated on 05/28/14 was a self referral an have had a signature referral was obtained 2. A policy titled "Init Assessments" dated assessment visit mus 48 hours of the referr 484.55(b)(1) COMPL COMPREHENSIVE ATTHERESIVE	al & Comprehensive 08/22/11 stated, "The initial at be performed either within al " ETION OF THE ASSESSMENT assessment must be manner, consistent with the eeds, but no later than 5	G:	334			
	This STANDARD is i	not met as evidenced by:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		R	-C	
		157641	B. WING			05/	28/2014	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	·		
VAL CO 11	EALTHCADE SEDVICES	INC		10	950 E 86TH ST ,SUITE 55-B			
VALCO H	EALTHCARE SERVICES	INC		IN	IDIANAPOLIS, IN 46240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 334	interview, the agency comprehensive asse accurate, and consist for 3 of 4 records rev to affect all 21 patien the agency. (# 2, 11, Findings include: 1. Clinical record nuincluded a Comprehe Assessment dated of incomplete and inaccurate was incomplete and incomplete and incomplete and incomplete and insurgical history, imminerasons for hospitalizations in the assessment stated the "asthma attack" (no admission) but the restated end stage rensistated end stage rensistatus was checked awere not assessed or blood pressure was assessment of the heand diabetic foot exa assessment failed to restrictions but inaccurate was set up on "meals plenty of water and a consisting of the four psychosocial was chestated the patient had The genitourinary, elicitated services assessment and a consisting of the four psychosocial was chestated the patient had The genitourinary, elicitated services and consisting of the four psychosocial was chestated the patient had The genitourinary, elicitated services and consisting of the four psychosocial was chestated the patient had	cord and policy review and refailed to ensure symmetrs were complete, tent with the patient's needs iewed creating the potential ts receiving services within and 12) Imber 2, SOC 05/05/14, ensive Non-skilled 5/05/14, that was found to be curate. The patient history failed to indicate the patient's unizations, and dates and cations (patient was a new	G	334				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 05/28/2014	
	ROVIDER OR SUPPLIER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	I	00/20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 334	plan, musculoskeleta it was indicated "no cassessment failed to and cognitive impair." Factors for re-hospit failed to indicate urin 10 or more medication daily living). Safety rebleeding precautions heparin during dialyst plavix 75 mg (milligra assessment indicate assessment when the pressure medication. "Don't stop meds (me "Don't miss dialysis as a. The Administration and was patient was on a reneation and was patient was on a reneation was a self referral and Director of Nursing) of hospital records. b. The Dialysis 05/28/14 and returned Dietician from the dia 05/29/14 that patient diet and 1500 ml (mid Dietician also indicate receiving meals on we breakfast and lunch apartment building.	the home health aide care all assessment incomplete as change," and fall risk include age, incontinence, ment. Assessment of Risk alization and emergent care ary incontinence, confusion, ons, and ADL (activities of measures failed to include as the patient received is and was also prescribed ams) daily. Medication d'no changes" since last ere was a change in blood Education provided were edications) abruptly" and	G 3	34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		157641	B. WING _			R-C 05/28/2014		
	ROVIDER OR SUPPLIER	ES INC		STREET ADDRESS, CITY, STATE, ZIP CO 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240	•	33/23/2014		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE		
G 334	self due to patient confused for a lon able to compreher 2. Clinical record included a Compreher Assessment dated and inaccurate. Tindicate the reaso evidenced the patito evidence how the impacted the patito evidence how the pulmonary assess was receiving oxyper minute as need there was humidifficated assessment indicated frequent nose bleed intermittent treatmed flonase to each not failed to indicate if verbalized compliants provided and the passessment failed (renal diet), appeting fair but disease in poor; neuro / emotificated to evidence antidepressant (pasafety measures in section and failed precautions as we section was left ble patient had oxyge. 3. Clinical record	he patient's ability to care for had been disoriented and g period of time and was not a simple directions. number 11, SOC 04/30/14, ehensive Non-Skilled Admission d 4/30/14 that was incomplete the assessment failed to an for home health services; ient had blurred vision but failed the impaired vision interfered / ent's function / safety; iment evidenced the patient gen via nasal cannula at 3 liters ded but failed to evidence if faction with the oxygen (nose ated the patient was having eds) and failed to include ents (duonebs nebulizer ents, albuterol inhalers, and estril); cardiac assessment if the patient had demonstrated / fance with health education olan of care; nutritional to evidence a weight and diet it was checked off as being management stated, "Appetite obtional / behavior assessment the patient was receiving an exil), the dose and frequency; and a diagonal line through the to indicate bleeding and fall all as walker / cane; allergies ank; and failed to indicate if the	G	334				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILD	· · · ·			-C
		157641	B. WING				28/2014
NAME OF PF	ROVIDER OR SUPPLIER	•	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				1	050 E 86TH ST ,SUITE 55-B		
VALCO HE	EALTHCARE SERVICES	INC		li li	NDIANAPOLIS, IN 46240		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
G 334	Continued From pag	e 58	G	334			
0 00 .				JJ-			
	failed to evidence the	on pages 2 to 20; Medicare					
		ocial Security Number					
		/ Triage Code; DNR order					
		ed); episode timing (M0110);					
		dered start of care (M0102);					
	-	M1010); Inpatient Procedure					
		history and diagnoses; a					
	diagnosis for the anti	i-cancer medication (Amidex)					
	(M1022); advance di	rectives; how impaired vision					
	interfered / impacted	the patient's function / safety					
	(M1200); and (M124						
		idocrine assessment failed to					
		f monitoring of blood sugars;					
	competency assessr						
	•	ms, anemia, and thyroid.					
	-	tatus (M1302 and M1320) Detic foot exam indicated the					
	patient assesses her						
	· ·) stated the patient was blind.					
		y assessment failed to					
		reatments such as medicated					
		se management problems;					
		0) was checked off "no					
	problem" but the plan	of care stated "The patient					
	will experience no ar	eas of skin breakdown or					
	redness due to incor	tinence. The Fall Risk					
		indicate diagnosis of 3 or					
	more, pain affecting						
	incontinence, cardiov	· · · · · · · · · · · · · · · · · · ·					
		nanging the patients score of					
	` ,	d Patient / Caregiver High					
	•	s (M2010) indicated "N/A"					
		n the patient had been					
	•	volog), 2 oral diabetic					
		e and metformin), antiplatelet					
	(plavix), diuretics / ar						
	(hydrochlorothiazide	mil ER, Lisinopril, Metoprolol					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		157641	B. WING				-C
NAME OF PI	ROVIDER OR SUPPLIER	101011		STR	REET ADDRESS, CITY, STATE, ZIP CODE	05/	28/2014
				105	0 E 86TH ST ,SUITE 55-B		
VALCO HE	EALTHCARE SERVICES	INC		IND	DIANAPOLIS, IN 46240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
G 334	Continued From page		G:	334			
	failed to indicated ble supplies failed to indi Summary checklist fa drug therapy, and pat failed to indicate if the	-convulsant / mood epine ER). Safety measures eding precautions; DME cate all diabetic supplies; iled to identify duplicate ient / caregiver education					
	05/15/14 failed to evid and identification num physician identification (M0018); Patient ID (I (M0063); Social Secut Emergency Triage Corequested), episode the for the anti-cancer me Primary Caregiver / Show impaired vision in patient's function / sa foot exam indicated the daily but vision assessment failed to treatments such as medisease management Endocrine assessment fequency of monitoring Genitourinary (M1610 problem" but the plant will experience no are redness due to incompassessment failed to the last 3 months, par incontinence / urgence	M0020); Medicare number rity Number (M0064), ode, DNR order (obtained or iming (M0110); a diagnosis edication (Amidex) (M1022); supportive Assistance; and interfered / impact the fety (M1200). The Diabetic ne patient assesses her feet sment (M1200) stated the e Cardiopulmonary include intermittent edicated inhalation and problems (M1400); int failed to indicate					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157641	B. WING _			R-C 05/28/2014	
	AME OF PROVIDER OR SUPPLIER ALCO HEALTHCARE SERVICES INC STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240			03/20/2014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 334		e 60 dicate bleeding precautions; edication status check off	G	334			
	orders written 05/13/ to address duplicate	ations (4 new medication 14). The assessment failed drug therapy and durable upplies failed to indicate all					
	assessment will be possible to incomprehensive to incomprehensive patients of the progress toward goal	08/22/11 stated, "The atient specific and clude the patient's need for tive care, social, and eeds During the initial and int assessment, all baseline easuring the patient's					
G 337	dated 08/22/11 stated the patient's assessm Documentation in the	eclinical record should ent as well as the actions	GG	337			
	review of all medicati using in order to iden effects and drug read drug therapy, signific	assessment must include a ons the patient is currently tify any potential adverse tions, including ineffective ant side effects, significant blicate drug therapy, and drug therapy.					
		not met as evidenced by: ord and policy review and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		157641	B. WING		R-C 05/28/2014		
NAME OF PROVIDER OR SUPPLIER VALCO HEALTHCARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP COI 1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
G 337	2 of 4 records review affect all of the agency receiving services. (Findings include: 1. Clinical record nurincluded a physician increase the amlodip 10 mg. The medication the new dosage. 2. Clinical record nurnurse visit note dated patient was prescribe (milligrams) 1 tab twice (potassium suppleme ER (extended release hydrochlorothiazide 2 physician order dated 3.125 mg 1 tab by mg M20 20 meq ER 1 tal and hydrochlorothiazidaily, and nitroglyceriminutes, maximum 3 pain. The medication phydrochlorothiazide cand failed to include the every 5 minutes up to 3. The Director of Nurunable to provide any	failed to ensure the s current and up to date for ed creating the potential to ey's 21 current patients \$\frac{1}{2}\$ and 12) mber 2, SOC 05/05/14, order dated 05/08/14 to ne from 5 mg (milligrams) to on profile failed to evidence mber 12 included a skilled 104/17/14 tahat identified the d Carvidolol 3.125 mg are a day, Klor - Con M20 and 20 meq (milliequivalent) and 25 mg 1 tab daily with food, and 25 mg 1 tab daily. A 105/13/14 was for Carvidolol buth twice a day, Klor-Con a by mouth daily with food, and 25 mg 1 tab by mouth on 0.4 mg 1 tab by mouth on 0.4 mg 1 tab every 5 tabs as needed for chest profile failed to evidence the losage had been increased the nitroglycerin 0.4 mg 1 tab	G 3	37			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	457644	B. WING		R-C	
ANNE OF PROVIDER OR OVERLYER	157641	D. WING_	0.TDEET ADDRESS OFT OTHER TIP CODE		05/28/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALCO HEALTHCARE SERVICES IN	С		1050 E 86TH ST ,SUITE 55-B		
VILEGO III. II. III. III. GERNIGEO III. G			INDIANAPOLIS, IN 46240		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
dated 08/22/11 stated, 'all medications for drug adverse effects and dru	sessment / Recertification" "Drug regimen review of interactions, potential g reactions, duplicative e drug therapy, significant	G	337		